for the following reasons: The dilated stomach is drained into the jejunum. Pyloric obstruction diverts bile and pancreatic fluid into the jejunum and prevents regurgitation into the stomach. Bile, pancreatic, and duodenal fluid with the contained hormones, so greatly needed, are more largely conserved than if the pylorus were not occluded. Regurgitation into the stomach and loss of fluids is lessened through cessation of vomiting—more certainly obtained in gastro-enterostomy with pyloric occlusion than in duodenojejunostomy. Pyloric occlusion is essential. Five months have elapsed since this operation was done, and the infant weighed then 12 pounds and 8 ounces.

Futility of Bridging Nerve Defects by Means of Nerve Flaps.—STOOKEY (*Surg., Gynec. and Obst.*, 1919, xxix, 287) presents a very thorough study of clinical, experimental and anatomical data from the literature and says that the repair of nerve defects by means of nerve flaps has not been definitely supported clinically, as evidenced by a critical study of the reported cases. Experimentally it has been shown that nerve flaps do not serve as conducting paths for the downgrowing neuraxes. Nerve flaps whether central or peripheral are merely degenerated partial nerve segments. Continuity and union of neuraxes does not take place at point of suture. To avoid fallacious deductions it is important to distinguish between the level of the injury to the nerve trunk and the level at which muscular branches arise. Abnormal communicating branches are not rare, particularly between the median and ulnar. Such anomalies must be taken into consideration of any careful study of nerve injuries. Judging from the level of the lesion, muscles may not be presumed paralyzed but should be demonstrated paralyzed. Total movements may not be offered as evidence of return of function. The action of individual muscles must be given. Reports of peripheral nerve injuries, to be of value, must be accompanied by motor, sensory and electrical findings. By the formation of nerve flaps from the central stump a portion of the nerve from which neuraxes must grow is removed. Distal as well as central flaps may sever muscular branches. By reversing the flaps they are taken out of their field. Thus the downgrowing neuraxes are prevented from reaching their muscles through these muscular branches, even were regeneration to take place. The nerve flap method to bridge nerve defects should be discarded in peripheral nerve surgery.

Early Surgical and Orthopedic Treatment of Hemiplegia.—BYRNE, TAYLOR and BOORSTEIN (*Surg., Gynec. and Obst.*, 1919, xxix, 398) says that early operation within two to four weeks, or even after a much longer period, may be indicated in hemiplegia: (*a*) Where the intracranial pressure threatens medullary strangulation, no matter what the site or nature of the lesion; (*b*) in extradural hemorrhage, with or without intradural hemorrhage, or cerebral contusion, where cerebral compression threatens life or permanent disability; (*c*) in intradural hemorrhage of traumatic or spontaneous origin where cerebral compression threatens life or permanent disability; (*d*) in intracerebral hemorrhage where focal compression threatens life or permanent disability. A subtemporal decompression and evacuation of the clot is a simple procedure and should be used in every case of fresh hemiplegia where the above-mentioned indications are present. If the patient be unconscious, an anesthetic need not be used, as the shock of the operation is small. Even in old cases of hemiplegia decompression is of benefit. Decompression should be used even in cases due to embolism or thrombosis. The deformities and contractures of hemiplegia can be prevented. Patients with hemiplegia should be put in the same category as anterior poliomyelitis and receive proper orthopedic treatments from the beginning. Plaster splints should be applied immediately to prevent contractures. Massage and exercises are indicated and should be used intelligently. Proper use of the limbs should be shown to the patients and encouraged. In old and neglected cases deformities should be corrected and recurrences prevented.

Gunshot Injuries of the Knee-joint in a Base Hospital.—DAVID (*Ann. Surg*,, 1919, lxx, 290) says that of the gunshot wounds of the knee coming to a base hospital after operation, 56 per cent. remained uninfected and 44 per cent. infected. Of the infected cases, 5 required amputations, with one ensuing fatality. Infection of the joint plays the most important role in decreasing the function of the joint. Early operation at the front, thorough débridement of the wound, removal of foreign bodies and loose bone fragments from the joint, and closure of the capsule of the joint are the most important elements in preventing infection of the joint. Almost 50 per cent. of joints having fractures of the articular surfaces became infected after operation, whereas only 33 per cent. of other types of injury to the joint became infected. Of the high explosive fractures of the condyles of the femur nearly 60 per cent. were uninfected after operation. Fractures of the tibia did not do so well. Joints remaining uninfected after operation for fracture of the articular surfaces had normal motion, to 90 per cent. active motion in 70 per cent. of the cases. Whenever possible, injured or infected joints were actively mobilized after operation, but active mobilization is not practicable in all war injuries of joints. Of the infected joints, all that were by necessity immobilized had only ten degrees or less active motion two months after injury. Of those actively mobilized immediately after drainage of the joint, two had normal motion and the remainder better than twenty degrees of active motion two months after injury.

Surgical Treatment and Prognosis of Empyema Following La Grippe.—LEYVA and LEGENDRE (*Surg., Gynec. and Obst.*, 1919, xxix, 17) say that during the past year they had the privilege of treating in their war service 27 patients suffering from empyema, the empyema in all but one case following la grippe. Eight died and nineteen were cured or are recovering. They studied the cause of the high mortality and concluded that the prognosis in empyema is not based on the nature of the microorganism causing the condition but principally upon the condition of the lungs. As pleurisy starts early with grippe, they believe it is best for the patients, to treat them medically by aspiration and injection with with specific sera, until the pulmonary symptoms have subsided. At this time surgical intervention has every chance of success. The microorganism causing the pleurisy has no bearing on the type of operation to be performed. In pleurisy developing late in la grippe the pleurotomy opening must be large, extending backward; resection of a rib is a necessity. The classic treatment consisting in drainage without irrigation is the method of choice.